Northern Nevada Planning Council

Ryan White Title II Standards of Care: Case Management (DRAFT August 2005)

I. Purpose/Goal - Within Ryan White standards of care, case management plays a key role. Its purpose is to successfully work with and link together service providers with clients and their families and to ensure access to and mobility within the continuum of care. Quality case management services should include the following:

a. Making sure services are available in a broad range of service settings and working together to meet client needs.
b. Increasing access to needed services.
c. Providing continuity of care at various stages of need without interruption while working with different agencies and support services.
d. Supporting and promoting the independent functioning of the client and his/her family unit.
e. Increasing client knowledge regarding HIV disease and teaching the importance of positive health behaviors.
f. Providing assessment and service planning that is comprehensive and addresses all major areas of living (psychosocial, medical, financial, etc)
g. Ensuring a client's right to: quality of life; privacy; confidentiality; self-determination; compassionate and non-judgmental care; dignity and respect.

II. Process Steps

a. Intake – Prospective clients who request or are referred for case management services are screened and evaluated for eligibility through a brief information gathering and decision making process. Information is gathered on the client, family and/or partner/significant other and current problem(s) as well as other services the client may currently be using. At this stage, the focus on gathering information is on the problem or need that the client presents.
b. Client Assessment – The collection of data regarding the client's medical, mental, social, legal, housing and financial circumstances continues, as does the evaluation of how these activities of daily life affect the client's ability to function independently. Completion of the Client Assessment will provide the case manager with information, which will help in fully understanding the client's

current situation, as well as those problems or concerns that may arise in the future.

c. Development of Service Care Plan – The translation of the assessment information into specific treatment goals, objectives and outcomes. Specific services and providers are identified who will be responsible for providing services, with an appropriate course of action to address problems. Active participation of the client, medical and human service caregivers and significant others is encouraged. At this stage, the case manager should think proactively, using identified client needs to anticipate emerging needs as the illness progresses and identify appropriate resources to meet needs and resolve problems.

d. Implementation of Service Care Plan – Obtaining and coordinating services that occur through inter-agency referrals or provision of the services directly by appropriate persons within the same agency. Provision of services may also include educating the client and providing support to enable the client to access services. Clients should be given the most recent list or booklet of resources and services that are offered in the community that are available to them, including eligibility specifications.

e. Monitoring of Service Care Plan – Provide routine tracking of the referrals made and whether or not the services were successfully delivered to the client's satisfaction. When there has been a problem obtaining services, identify and start corrective actions as needed.

f. Update/ Revision of Service Care Plan - Review success in carrying out the Service Care Plan and determine whether client needs have significantly changed since the previous assessment. The plan should be changed if needs or circumstances have changed. At a minimum, this plan should be updated every twelve (12) months.

g. Closure – Discharging the client from the case management process due to client request, agency termination or client death.

III. Record Management: Maintaining Client Information

Confidentiality

All written and verbal communications pertaining to individual clients shall be maintained in strict confidentiality according to each agency's written policy and state law. All designated agency staff with access to client information shall receive training on confidentiality, the proper exchange of information, and required consent.

Before any information is provided to or received from other agencies that may be involved in the care of the client, the case manager must obtain written informed consent from the client. This means that the client must agree to the sharing of the information. In order for the consent to be informed, the case manager must be sure that the client understands that the consent means that information will be shared with or received from other agencies, and the impact of sharing that information. A situation in which information must be shared without client consent would be a threatened suicide or harm to others. The consent will always include information regarding:

- The name of the actual agency to release or receive the information
- The type of information to be shared
- The purpose or need for the information
- The length of time during which the consent is valid
- Information regarding how to cancel consent

IV. Cultural/ Language/ Reading Level Accessibility

Written Information

Written consent should be available in the client's primary language, written at no higher than a 3rd grade level, and signed by a minimum of the client and a witness. If the written consent is not available in the client's primary language, the form should be verbally translated by a staff member who speaks the client's primary language, and a written statement added to the form indicating that translation was provided, who provided it and that the material was understood to the satisfaction of the translator.

V. Engagement and Retention of Clients

Efforts will be made to engage and retain clients in case management. This is a particularly important point when providing services to traditionally underserved and/or resistant clients such as drug users. Before determining that a client should be discharged or terminated from case management services, the following steps will be taken:
If a client misses an appointment:

1. The case manager will call the client within two (2) days of the missed appointment if the client has been deemed a level I or II acuity level, to determine why the client could not keep the scheduled appointment. Staff will attempt to reach the client no less than two (2) times during a workweek period. However, if the acuity level has been determined to be a level III, the client will be called within one (1) day to follow-up on why the client did not arrive for the scheduled appointment. If a level III client does not respond within that same day, emergency contacts will be contacted.
2. If unable to reach the client by phone two (2) days after the missed appointment or one (1) day for level III clients, the staff member will attempt to contact the emergency contact listed on the client's intake form no less than three (3) times and attempt to find out why the client did not show up.
3. If unable to reach the emergency contact, the staff member will send a letter to the client stating that an appointment was missed and requesting that the client contact the agency to set up another appointment
4. If there is no response to the letter, if possible, the case manager will go out to the client's last known address to attempt to locate and speak to the client.
5. All verbal and written efforts to contact the client will be documented in the client record, with copies of any written correspondence sent.

The case manager may choose to discharge the client after all attempts to contact the client (i.e. phone, letter, visit) have been made with no response from the client within a 6 month period.

VI. Client Caseloads

Clients require different levels of assistance and support often based on the stage of HIV disease they are in, their pre-existing problems, and/or their ability to negotiate the system of care. In order to identify an appropriate caseload for case managers, the amount of time and effort needed to assist the client must be considered as well as the number of actual clients to be worked with.

Therefore, the following level system has been developed to identify those clients who would need minimal assistance, and those who would need more. The number of clients with which the case manager works will decrease as the intensity of the involvement with the client increases.

The following levels of acuity assume that the case manager has taken into account the physical condition and current medical treatment regime of the client when determining the level the client is gauged.

- **Level I**

Clients with few needs, either in early stage of HIV infection or those who have strong support systems and resources that are readily available. Minimal monitoring required. These clients are basically stable but have some needs.

- food, clothing, and other sustenance items available
- has insurance/public assistance/ability to pay
- clean, habitable housing that is not in jeopardy
- no history of mental illness or need for psychotropic medications
- no current difficulties with alcohol, drugs, or gambling
- has dependable availability of relatives and/or friends to help
- understands service system and language is not a barrier to accessing services

- **Level II**

Clients who have certain needs addressed but still require assistance to manage changing multiple health and social needs.

- Sustenance needs met on a regular basis w/ some periods of lapse
- Needs information and guidance accessing insurance or public assistance
- Needs short term housing assistance
- History of mental disorder or disturbances
- Problems with alcohol, drugs or less than one year of sobriety. Expresses desire for help in overcoming drug abuse or gambling
- Gaps exist in support system; family and/or friends periodically available when crises occur.
- Needs interpretation services

- **Level III**

Clients with end-stage HIV disease are highly symptomatic and require the most intensive management. This would also include families with intensive needs for intervention.

- Has no access to food; unable to perform ADL
- Not currently eligible for insurance and/or public assistance
- Homeless; evicted; arrangements to stay with friends/family not available
- Danger to self or others; needs psychiatric intervention
- Current relapse/binge
- Unable to cope without professional support
- Lack of understanding of service system; language creates a state of fear/anxiety and distrust in client and/or family; crises intervention necessary

VII. Case Transfer and Discharge

Case managed clients should be assigned to a new case manager, if possible, when:

- A client requests a new worker, the grievance process is followed, an alternative exists and the case management supervisor concur
- A case manager or agency requests a change, an alternative exists and the case management supervisor concurs
- The case management supervisor determines that a transfer is appropriate through routine supervision
- A client moves out of the service area
- Case management services at the agency no longer exist
- Prior to transfer, the case management supervisor should ensure that:
    - The client is notified of the change and name of the new contact person
    - The supervisor and case manager have met and discussed the client's status
    - A thorough transfer summary note is completed by the case manager and placed in the client record and forwarded to the new case manager, if applicable
    - The case manager is informed of agency policy regarding termination of contact with clients following case transfer
    - The case manager does not remove confidential client or agency materials upon transfer or termination of employment

Agencies should have policies and procedures that outline the specific components of client discharge, including the criteria and circumstances under which clients are discharged, procedures to follow in discharging a client, and a description of the client appeal process.

Documentation

The case manager will be named in the client's record. The record should also show evidence of coordination with service providers from other agencies involved in providing care to the client. In these instances, the service plan must document how coordination efforts will be achieved, and identify each provider's responsibilities and tasks to address each need identified by the client and case manager. This documentation must include the client's assessment, the initial and updated service care plans, monitoring and progress notes including indication of multi-agency coordination and crisis intervention.

In addition to documentation requirements noted throughout these guidelines, adequate documentation for case management services delivered must be maintained in the record. Required documentation includes a minimum of the following:

- The date of service, transfer, or discharge
- The name of the person providing the service
- Description of the case management service
- Signature/ initials of case manager and/or provider

All case management record entries that are handwritten must be legible.

VIII. Case Management Process

The responsibilities and tasks identified in each step in the case management process will sometimes overlap, occur simultaneously with one another, and/or occur in a different order. It is noted that the health status of the client ranges from asymptomatic to symptomatic and that emergency needs will differ on a case-by-case basis. In certain cases, the order in which the case management activities occur will have to be modified to meet immediate client need.

❑ The Intake (Step 1)

The following minimal standards will be met by all agencies funded by the Northern Nevada Planning Council to provide Case Management Services under Title II of the Ryan White CARE Act.

Process:

These steps must be completed during a face-to-face visit in a setting that is comfortable for the client.

1. A staff person and/or volunteer, with appropriate training, screens the service request/ referral for basic admission criteria and assesses the need for immediate intervention.
2. Critical demographic and case specific information is collected directly from the prospective client and/or referral source and the prospective client is informed of agency services and limitations (i.e. what the case management services of the agency can and cannot provide).
3. A decision is made by the prospective client and case manager performing the intake to enroll the client, not to enroll and/or refer to an appropriate agency or service. If the client is not eligible for case management services or chooses not to use them, but there is a need identified, the worker completing the intake must make an appropriate referral to an agency that can be of assistance.
4. If the client is enrolled with the case management agency, the worker completing the intake will provide the following information to the client at that time:
    a. All the health and support services available, the regular and emergency hours of operation, and other case management procedures.
    b. How to access case management services in case of emergency on weekends and holidays.
    c. The case management agency's grievance procedure.
    d. The role of the Ryan White Title II Planning Council to plan, develop and deliver comprehensive health and support services to meet the identified needs of individuals with HIV/AIDS. This matter may be presented in writing in a language that the client can read, and at no more than a 3rd grade reading level.
    e. His/her rights to confidentiality. A consent form will then be presented, explained, and signed by the client in order to release/receive confidential information.
    f. A copy of the Clients Rights and Responsibilities that is reviewed, signed and dated by the client. Another signed copy will remain in the record.
5. Document the result of the intake on the form and if the client is enrolled. Begin a client file to be maintained throughout the time that the client is receiving case management services at the agency.

Criteria:

1. Within 48 hours of the referral or client-initiated contact, the client will receive written or phone confirmation of the appointment for intake. During this confirmation, prospective clients will be provided with information that they will need to bring with them in order to determine eligibility for services (i.e. proof of HIV status, financial information, proof of residency, etc.)
2. Intake will be initiated within seven (7) working days of the client referral or self-referral. If a scheduled appointment for intake must be cancelled by the agency, the client will be notified the day before whenever possible, but minimally at least four (4) hours in advance, and an alternative intake date will be established within three (3) days of the original intake date.

Documentation: The intake must include documentation of the following:

- Date of intake
- Client name
- Name of case manager
- Place of residence
- Gender/date of birth/ race/ethnic origin
- Documentation of HIV status (source of test; when and where performed)
- Communication method to be used for follow-up
- Preferred language of communication
- Source of referral
- Presenting problems identified by the client
- Employment status
- Living arrangements
- Current insurance status
- Gross annual income from all sources
- Financial situation
- Information about significant others/ partners/ minor children
- Individuals who are aware of client's HIV status
- Client's choice concerning management of confidential and personal information
- A representative, if any, who the client would like involved in client conference and case management meetings with him/her.

- **Individual Assessment (Step 2)**

This is an information-gathering step of the case management process that includes at least one face-to-face interview between the client, his/her family or significant other(s), and the case manager, as well as obtaining additional information from health and human service professionals. It may also include a review of other assessments and evaluations that have been completed by other agencies if available. These assessments may have been completed to identify client needs, strengths and weaknesses, and individual community support systems that are already being accessed.

Assessment identifies:

- The amount and nature of client needs
- The capability of the client to meet personal needs
- The capability of the client's social network to address the client's needs
- The capability of available human services to address client needs
- The client's knowledge of HIV disease and primary and secondary prevention techniques.

Assessment is focused on reaching a mutual agreement between the case manager, the client, and the client's family and/or significant other concerning priority needs and the client's areas of strengths and limitations.

<u>Process:</u>

1. Assessment is conducted by case managers and is performed in accordance with written policies and procedures established by each case management agency, consistent with the Northern Nevada Planning Council's Case Management Standards and Guidelines.
2. The face-to-face interview is conducted at a site, which is mutually acceptable to the client and the case manager.
3. The process for identifying client needs and strengths should be a participatory activity that involves client self-assessment and encourages the client's ability to make choices and decisions. Also important is ongoing collaboration between the case manager and other health and human service providers and other individuals actively involved with the client.

Criteria:

1. After a client's case is officially opened, an assessment is conducted by the case manager or other appropriately trained staff.

Time Frames Required: Within three (3) working days following intake and the determination of eligibility for case management services, the client is notified of a scheduled appointment for assessment. This time-frame allows the case manager to contact other service and/or providers who will be involved with the care of the client. Client assessment is usually conducted in one or two face-to-face meetings between the client and case manager, starting no later than seven (7) days (4 days after notification) following intake.

2. The client's needs, strengths and resources are assessed, documented and summarized. This involves the active participation of the client, health and human service providers, and other individuals, such as family members, the client's support network and/or significant others in identifying client needs and supports in the following areas:
    - Income
    - Financial resources (identification of and coordination with insurance, veterans' benefits and other sources of financial assistance, entitlements)
    - Housing/shelter (residential support, Section 8 funding, appropriateness of current housing)
    - Employment (current and past employment, interest in returning to work)
    - Education status (prognosis for employment, educational/vocational needs, appropriateness and/or availability of education, rehabilitation and vocational programs)
    - Physical and dental health assessments, health status, diagnosis, possible treatments, consideration of potential rehabilitation, client's needs regarding treatment and client's right to refuse care or insist upon a different approach
    - Nutritional status and access to food
    - Mental health and emotional status, level of coping and functioning and past coping strategies that were tried, assessment of clients' emotional strengths and weaknesses
    - Cultural, ethnic, racial, religious/spiritual considerations, self-care knowledge, sexual orientation/issues, and possible risky sexual behaviors
    - Communication skills, literacy and/or translation requirements

- Social skills
- Social relationships and support (informal care givers, formal service providers, significant issues in relationships, social environments)
- Family issues and parenting/children's needs
- Client's physical environment, especially regarding mobility in home and accessibility
- Recreation and leisure
- Activities of daily living (ADL)
- Transportation capabilities
- Legal status, if appropriate (guardian relationships, health care proxy, involvement with the legal system, citizenship status)
- Knowledge of and accessibility to community resources which the client wants or needs
- Assessment of drug and/or alcohol use and misuse

Documentation:

The client record must include documentation of the assessment information on an approved Assessment Form

- Information received by other sources
- Completed assessments will be reviewed and co-signed by the case management supervisor

- **Service Care Plans (Step 3)**

This is a "plan of action" which includes responses (services, resources, and staff responsibility) to all the individual and family needs that were identified in the assessment and acts as a "bridge" from the assessment to the actual delivery of services. The major components of the Service Care Plan include identification of priority client needs and those of the client's family. It also includes the development of service goals, measurable time-specific objectives, action steps and expected outcomes. The purpose of the service plan is to enhance the client's access to services, to improve coordination of care, and to ensure case management accountability.

The case manager and the client work together to develop the service plan. It is a process that supports client choice and decision-making and encourages the client to participate actively in the planning and delivery of services. The case manager has primary responsibility for the development of the service plan in conjunction with the client, family members and other provider agencies. Under certain circumstances (i.e. client neurological impairment or crisis situation, etc.) decision-making may be deferred to a client representative designated by the client, along with the case manager serving as advisor if requested. It is the professional responsibility of the case manger to analyze client needs and to discuss service plan alternatives with the client. This should include a discussion of anticipated outcomes or consequences in choosing alternatives and options for the service plan.

The role of the case manager is mainly one of resource coordination and follow through. Case managers must try to reduce service, agency, and administrative barriers to ensure that clients obtain services as quickly as needed and in a manner satisfactory to them. The function of case management is a process of contacting both formal and informal providers to arrange for services outlined in the Service Care Plan. Actions to be taken by the client, case manager and others, including family members, should be clearly defined.

Process:

1. Service plan development is conducted by a case manager and is performed in accordance with written policies and procedures established by their respective agencies, using a standard Service Plan form. After completion of the assessment, the case manager develops a problem list of the most urgent client needs.
2. The service plan is developed by the case manager who:
    - Works with the client to prioritize the needs of the client and his/her family to be met through case management
    - Establishes measurable goals, objectives and outcomes expected to address those needs
    - Establishes action steps to meet the service plan goals and objectives
    - Describes how success (outcomes) will be measured
    - Identifies formal and informal resources to accomplish goals, including agencies to which the client will be referred and, if possible, specific individuals within those agencies
    - Projects realistic time frames for completing activities
    - Identifies gaps in services

- Identifies individual staff members within and outside the case management agency who are responsible for completing the identified activities.
- Identifies potential barriers to receiving services (admission criteria, client attitudes or resistance, etc.) and proposes solutions to these problems

3. The case manager and client review, adjust as needed, authorize and implement the Service Care plan.
4. The client or client-identified representative is informed about and agrees to notify the case manager about changes in the client's status or significant problems encountered in receiving needed services.

Criteria:

1. Time Frames Required: Within seven (7) working days following the completion of the Assessment, a Service Care Plan is established by the case manager and recorded in the client record. The case manager and the client review the Assessment, adjust as needed, authorize and implement the service plan within a reasonable period of time. Thereafter, all service plans are to be reviewed and renewed at a minimum of once every twelve (12) months and documented by the case manager.
2. The service plan will identify who is responsible for contacting the referral sources and follow-up upon the initiation of service.

Documentation: The client record includes documentation of the following:

1. A service plan signed and dated by the case manager and client or his/ her representative, which includes:
   - Description of the problem (s)
   - Description of what is to be done, i.e. the solution
   - A list of all formal and informal services to meet the need of identified problems
   - The quantity, frequency, time frame and desired outcomes and provider of service
   - Payment sources for services
2. Case management supervisor's signature on the Service Care Plan indicating supervisory input and review.
3. Notations of service plan changes, signed and dated by the case manager and the client.

- **Implementation of Plan and Coordination of Services (Step 4)**

Service plan implementation and coordination is the ongoing responsibility of the case manager and begins immediately after the Service Care Plan has been put into effect.

The service plan may be modified to accommodate the client, family members, significant others, and service providers. Any changes from the original plan should be noted in the record.

Therefore, the case manager should develop relationships with multiple providers for each type of service, where available. Case managers should discuss with clients, the pros and cons of each option for service delivery and if needed, assist the client in choosing a provider.

Agencies which do provide the type of service a client needs and prefers should be directly involved in the development of a service plan, to the furthest extent possible. If not available for a face-to-face inter-agency meeting, there should still be an individual noted within that agency as being responsible for the type and units of service to be delivered, and time frames in the service plan.

There may be instances in which a client must wait a period of time for the service, such as housing. A waiting list should be maintained for clients who are requesting and are eligible to receive services. The process by which a client is placed on a waiting list and the average length of time for the service should be explained to the client.

<u>Process:</u>

1. Clients, consistent with the responsibilities identified in the Service Care Plan, should be encouraged to carry out the tasks to which they agreed. Case management staff should take into consideration client strengths and encourage active client participation to promote empowerment.
2. To the extent they are capable, family members and other involved individuals, as identified in the service plan, also take part in acquiring services by contacting providers, completing applications, etc.
3. It is the responsibility of the case manager to ensure and/or perform the following activities:

- Explain to the client the referral process for linking the client with the needed service
- Contact providers by phone, in writing or in person
- Assist the client, family members and/or significant others in making applications for services and entitlements, including basic needs such as transportation, childcare, housing, food stamps, etc.
- Confirm service delivery dates with providers and note in the record
- Schedule multiple visits for services for family members on the same day if such scheduling better accommodates the needs of the family and children
- Document services that are not available or cannot be accessed by the client and the reasons why
- Obtain assurance from other care providers that services will be initiated and confirm the delivery of these services by regularly monitoring the plan
- In conjunction with the client and other providers, determine and define the ongoing responsibilities of each provider and
- Give other service providers accurate and complete information about the service(s) they are expected to provide and the services provided by others (i.e. a copy of the plan if the client consents or a written note that states the terms of the service to be provided.)

4. Coordination of service delivery involves frequent contact between the case manager, provider agencies and the client and his/her support system to ensure that the services have been arranged and received. Guidelines for such contact include:
   - Upon determination of service need, assist the client with any necessary applications, or forms that need to be completed
   - Confirm approval of services to be provided and, if possible, set a date for the start date of service delivery
   - 24 – 48 hours prior to the arranged service delivery date confirm service delivery arrangements, including supports needed for client to receive service, such as child care or transportation, or
   - If an appointment for delivery of services has not been set, continue contacts with service provider to confirm a service delivery date.

<u>Criteria:</u>

1. Implementation of the Service Care Plan will be started within two (2) weeks of the plan being completed and agreed upon by the client and the case manager.
2. Applications for routine services and entitlements will be completed and submitted to the appropriate agency no more than two (2) weeks after the completion of the Service Care Plan

    a. Contact and follow-up within two (2) hours is required for services that are necessary to assure the immediate safety and health of the client, and
    b. For life-sustaining services that have been arranged through nursing or other home care referral, case managers should coordinate with hospital or health center case workers to confirm the receipt of services within 24 hours after the agreed upon service delivery date.

3. For routine services that are not immediately available upon referral and are not related to life safety, the case manager will continue to contact the requested service provider every other week (2x monthly) in an attempt to secure services. Services which have an acknowledged long-term waiting list (longer than 3 months) will be contacted every other month to determine the client's progress on the list.

Documentation: The client record includes documentation of the following:

1. Name of the person at each service provider agency noted as responsible to provide each service identified in the plan and the date by which that service is to be started. It will also include the time frame for service continuation. (i.e. how often the service will be delivered), and the number of units per week/ month etc.
2. Notation of the persons responsible for implementing contact with each needed service
3. Dates contacted, method of contact and name of person making contact for each service needed
4. Copies of any applications or referral forms completed
5. Record of all appointments confirmed for client, including date and person making confirmation
6. Record of all continued contacts made in an attempt to secure services not immediately available, documentation of all needed services that are not available to the client.

- **Monitoring of Service Care Plan (Step 5)**

Monitoring is an ongoing data collection process that ensures that services provided are consistent with the Service Care Plan. It begins after the development of the Service Care Plan and the implementation and coordination of services. How often monitoring takes place depends on the level and intensity of client need, as outlined under "Time Frame required" in this section. Monitoring involves collection and analysis of data and information and it results in the following:

- An evaluation of the appropriateness and effectiveness of the service plan
- Evaluation of the level of client satisfaction
- Judgment of the need for service plan revision

Process:

1. Monitoring is conducted through:
    a. Direct contact (i.e. face-to-face meetings and/or telephone conversations) with the client and/or his/her representative
    b. Indirect contact with the client, client's family and/or significant others, the primary care physician, service providers and other professionals, through meetings, telephone communications, written reports and letters, review of client records and related material and through client or agency staff.
2. The case manager obtains information on an ongoing and periodic basis concerning:
    a. Status of the client and family
    b. Satisfaction of client and/or client representative
    c. Quality and appropriateness of services provided
3. The client or client representative is counseled about and agrees to assume the responsibility for notifying the case manager about changes in the client's status or significant problems encountered in receiving services.
4. Any problems noted during monitoring contacts will be followed up immediately with the client, support person or providers as needed to address the problem.
5. Clients will be called every three (3) months for follow-up by the case manager if not seen regularly in the clinic or office. If not reached through a phone call (at least two attempts), a letter will be sent to the client. The case manager will document this in the client's comprehensive service care plan.

Criteria:

1. Within one (1) month following the completion and signing of the Service Care Plan and at least every three (3) months thereafter, face-to-face client contact is made by the case manager for purpose of monitoring the client's progress and evaluating the effectiveness of the plan. Client requests and reasons for less frequent contact are documented in the client record.
2. No less than one contact with the client or his/her representative must occur quarterly by telephone. Client requests and reasons for less frequent contact are documented in the client record.
3. There may be circumstances beyond the case manager's control which could impact the ability to comply with the minimum required telephone and face-to-face contact requirements. For example, case manager illness, staff shortages and emergency situations may make it necessary for the case management agency to shift workloads and prioritize the case manager's time. Documentation must reflect the specific reason, if the minimal contacts have not been completed.
4. At least annually, each case managed client is formally and objectively surveyed to assess client satisfaction with case management services and services coordinated under case management.

Documentation: The client record includes ongoing documentation, signed and dated by the case manager regarding the following:

1. All client contacts with client requests for less than standard amounts of contact
2. Contacts with client's support system, providers and other participants in the Service Care Plan which must be monitored
3. Reasons why the minimum number of required client contacts were not completed
4. Provision of service at intervals reflecting the outcome goals of the Service Care Plan
5. Changes in service delivery
6. Follow-up actions taken when problems with service deliver exist
7. Any inter-agency case conferences that are conducted
8. Supervisory signature on Service Care plan, indicating quarterly supervisory input and review.

- **Re-evaluation of Service Care Plan (Step 6)**

Clients are re-evaluated through a comprehensive assessment process that determines the client's current case management status and the need for revisions in the Service Care Plan. Revision of the Service Care Plan is conducted on a scheduled basis once every twelve (12) months or when unanticipated events or changes in the client's life demand it.

Updating the Service Care Plan means modifying or revising the plan based on the reassessment. Update of the service plan may also occur as a result of changes in the client's needs, or information from monitoring contacts when changes are not significant to require a formal reassessment.

Process:

Reassessment is conducted by the case manager with assistance from all members of the case management team who have worked with the client and their family in accordance with established standards and criteria. The process of reassessment will involve the collaboration between the case management team and other involved service providers, or individuals actively involved with the client and through client record review.

Criteria:

1. Active case managed clients will be reassessed at a minimum once every six (6) months and more frequently as needed.
2. Reassessment will include but not be limited to the original assessment areas and will include Service Care Plan status/progress, changes and mutually agreed upon goals. New goals, objectives and desired outcomes will be added as appropriate.

Documentation: The client record must include documentation of the following:

1. An updated summary of key personal data reflecting any changes in client status
2. A revised Service Care Plan
3. An updated list of current problems/concerns, strengths, personal and community support list network

4. Updated psychosocial and health assessments conducted face-to-face with the case manager
5. Updated secondary assessment data received from other service providers, such as current medical status.
6. Supervisory signature on the service plan indicating input and review.

- **Case Transfer and Discharge (Step 7)**

Clients are discharged from case management services through a systematic process that includes documentation in the client record of the following:

- The reason(s) for discharge
- Formal notification of the client of case termination or record closure and the appeal process and
- A discharge summary
- Exit planning for case closure is the responsibility of the case manager. A case closure summary, noting case outcome, client satisfaction and the progress toward the goals identified in the Service Care Plan should be completed on a standard form developed by the case management agency.

Process:

1. In the case of client death:
    a. The case manager will be notified of the client's death by the client's family, significant other, direct care provider, legal guardian or other designated person approved by the client.
    b. Appropriate referrals are made for the family and significant others (i.e. grief counseling, housing needs, support services, etc.)
    c. Case manager will notify and verify termination of all arranged services
    d. Case manager completes the case closure summary and it is reviewed and signed by the case management supervisor
2. In situations where the case is closed at the client's or client's representative's request:
    a. Appropriate referrals will be made on the client's behalf, if the client so desires. With the client's consent, a case summary should be prepared for referral to the new provider.
    b. Case manager will notify and verify termination of all arranged services.

c. Case manager completes the case closure summary and it is reviewed and signed by the case manager supervisor.

3. In situations where the case is closed due to client becoming ineligible for services (moves out of the county, has not maintained contact, etc.):
   a. Case manager will report to the supervisor the client's situation, actions, behavior (verbal and/or non-verbal) that make the client ineligible for case management services.
   b. Case manager notifies the supervisor of intent to discharge the client. (Supervisory involvement on final determination of discharge takes place only when discharge is initiated by the agency.).
   c. Case manager notifies the client (through face-to-face meeting, telephone conversation or letter) of plan to discharge him/her from case management services.
   d. Client receives written documentation explaining the reason(s) for discharge and the process to be followed if the client elects to appeal the reasons for discharge.
   e. Case manager completes the case closure summary and it is reviewed and signed by the case management supervisor.

<u>Criteria:</u>

1. Reasons for client discharge include:
   - Client relocation outside of agency service area
   - Service needs met – problems completely resolved
   - HIV sero-negative status
   - Noncompliance with service plan
   - Lack of contact
   - Client choice to terminate services
   - Abuse of/danger to agency staff, property or services as determined by agency policies and review of situation by agency administrative staff if appropriate
   - Death

2. Date of discharge is established by:
   - Date that case management agency and client or client representative agree on termination of services

- Date that case management agency determines and documents the client's ineligibility for case management services
- Date of client death

3. Within three (3) weeks of final decision to discontinue services, a client discharge/ termination summary is completed and signed by the case manager, reviewed and co-signed by the case management supervisory and placed in the client's record.

4. Client records are stored by the case management agency for a minimum of seven (7) years following closure, and two (2) years in case of death.

Documentation: The client record must include documentation of the following:

1. Progress notes reflecting action taken to close the case including:
    a. Reason(s) for discharge
    b. Formal client notification of case discharge/termination and the appeal process when the client became ineligible for service
2. A completed case closure summary